ATTACHMENT 7
Wisconsin Medicaid explanation of benefits codes for real-time and paper claims

The following table lists Wisconsin Medicaid explanation of benefits (EOB) codes that pharmacy providers will receive on real-time claim responses and paper Remittance and Status Reports. A separate *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

EOB message code	EOB message description
006	Amount paid reduced by amount of other insurance payment.
009	Recipient name missing. Please correct and resubmit.
010	Recipient is eligible for Medicare. Please bill Medicare first. Indicate Medicare disclaimer on claim if Medicare denied or attach the Explanation of Medicare Benefits if Medicare paid.
012	Service paid at the maximum amount allowed by Wisconsin Medicaid reimbursement policies.
014	A discrepancy was noted between the other insurance indicator, and the amount paid on your claim.
020	Claim reduced due to recipient spenddown.
024	Provider certification has been suspended by the Department of Health and Family Services (DHFS).
025	Provider certification has been cancelled by the DHFS.
029	Wisconsin Medicaid number does not match recipient's last name.
044	The provider is not authorized to perform or provide the service requested.
050	Payment reduced by recipient copayment.
060	*International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code is missing or invalid.
066	Claim reduced due to recipient/participant deductible.
084	Claim denied due to missing or invalid provider signature and/or billing date.
085	Different drug benefit programs. Prescriptions or services must be billed as a separate claim.
095	Generic or substitute invalid. Please correct and resubmit.
100	Claim previously/partially paid on (internal control number) on remittance advice (RA) date (DDMMYY). Adjust paid claim.
114	Schedule 3/4/5 drugs are limited to the original dispensing plus five refills or six months.
116	Procedure or drug code not a benefit on DOS.
129	Participant's eligibility not complete, please re-submit claim at a later date.
135	Denied. No substitute indicator required when billing innovative NDCs.
146	Non-scheduled legend drugs are limited to the original dispensing plus 11 refills or 12 months.
153	Claim denied due to missing and/or incorrect total billed amount.
158	Quantity billed is missing or exceeds the maximum allowed per DOS.
171	Denied. Claim/adjustment received after 12 months from DOS indicated on claim/adjustment.

EOB message code	EOB message description
172	Recipient's Wisconsin Medicaid number not eligible for DOS.
177	Denied. Procedure not payable for place of service or invalid place of service code submitted. Resubmit with correct place of service code for procedure provided.
183	Provider not authorized to perform procedure code and/or type of service code.
184	Procedure billed does not correspond with Wisconsin Medicaid age criteria guidelines.
185	Procedure billed is not appropriate to recipient's sex.
201	Performing provider not certified by Wisconsin Medicaid/prescribing Drug Enforcement Agency (DEA) number invalid for NDC billed.
203	Estimated days' supply missing or incorrect.
221	No charge was submitted for this procedure.
224	Quantity billed is missing or incorrect.
240	Prescription number is missing or incorrect.
242	Date prescription written is missing, invalid, after date of service (DOS) or exceeds one year. Please correct and resubmit.
247	Procedure code/NDC is invalid, obsolete, or not billable to Wisconsin Medicaid, or this procedure/type of service combination is invalid. Resubmit with valid Wisconsin Medicaid codes for the DOS.
277	Services billed are included in the nursing facility rate structure.
278	Denied. Recipient eligibility file indicates other insurance. Submit to other insurance carrier.
281	Recipient's Wisconsin Medicaid identification number is incorrect. Please verify and correct the Wisconsin Medicaid number and resubmit claim.
287	Claim denied. Recipient is enrolled in a Medicaid HMO or other managed care program.
289	Services performed by out-of-state providers are limited to those prior authorized or emergency in nature.
310	Traditional professional dispensing fee reimbursement policy applied.
322	Service(s) denied/cutback. The maximum prior authorized service limitation or frequency allowance has been exceeded.
324	EDS Federal has recouped payment for service(s) per provider request.
361	No more than two dispensing fees per month per prescription shall be paid.
369	The indicated legend drug shall be dispensed in amounts not to exceed 34 days.
376	The indicated legend drug shall be dispensed in amounts not to exceed a 100-days' supply.
388	Incorrect or invalid type of service/NDC/procedure code/accommodation code or ancillary code billed.
398	Prior authorization (PA) number submitted is missing or incorrect.
399	Date of service must fall between the PA grant date and expiration date.
400	Performing provider on the claim must be the same as the performing provider who received PA for this service.
424	Billing provider name/number is missing, mismatched, or unidentifiable. Indicate one billing provider name/number in the appropriate element.
425	Performing/prescribing provider number/DEA number is missing or unidentifiable. Please indicate separately on each detail.
426	Claim denied. Payment is limited to one unit dose service per calendar month, per legend drug, per recipient.
469	Claim is being processed through Special Handling. No action on your part is required. Please disregard additional messages for this claim.

EOB message code	EOB message description
477	Billing provider indicated on claim not allowable as a billing provider. A clinic, facility, or supervising provider must be the billing provider.
498	Pharmaceutical Care code must be billed with a valid Level of Effort.
509	Claim denied. Please verify the units and dollars billed. If correct, refer to Pharmacy Handbook for special billing instructions.
510	Denied. Prior authorization/diagnosis is required for a payment of this service. A valid PA number/diagnosis is required and/or the type of service/procedure must match the approved PA.
511	National Drug Code is only billable as a compound drug.
595	One service allowed per day. This procedure is denied as a duplicate.
614	Wisconsin Medicaid number does not match recipient's first name.
618	Claim denied. Unit dose indicator and/or submission clarification code billed is invalid with NDC billed.
619	Claim denied. Do not indicate "no substitute" on the claim when the NDC billed is for a generic drug.
630	A valid LOE is required for billing compound drugs or PC.
631	Recipient locked-in to a pharmacy provider or enrolled in a hospice. Contact recipient's hospice for a payment of services or resubmit with documentation of unrelated nature of care.
643	Billing provider not certified for the DOS.
683	Qualified Medicare Beneficiary Only recipient is allowable only for coinsurance and deductible on a Medicare crossover claim.
698	Recipient not eligible for Medicaid benefits.
751	Denied. No substitute indicator invalid for non-innovator drugs not on the current Wisconsin Maximum Allowed Cost (MAC) list.
843	All three DUR fields must indicate a valid value for prospective DUR. A valid LOE is also required for PC reimbursement.
846	Denied. This procedure code is not valid in the pharmacy Point-of-Sale (POS) system. Please resubmit on the CMS 1500 using the correct HCFA Common Procedure Coding System (HCPCS) procedure code.
852	Denied. Quantity must be a whole number for this NDC. Correct and resubmit.
853	Date of service is missing, incorrect, or contains future date.
877	The quantity allowed was reduced to a multiple of the product's packaging size.
887	Default prescribing physician number XX5555555 was indicated. Valid numbers are important for DUR purposes. Please obtain a valid number for future use.
888	Default prescribing physician number XX9999991 was indicated. Valid numbers are important for DUR purposes. Please verify that physician has no DEA number.
907	Our records indicate you have billed more than one unit dose dispensing fee for this calendar month. Reimbursement for this detail does not include unit dose dispensing fee.
920	Denied. A discrepancy exists between the other coverage (OC) indicator submitted and the OC information on the file for the recipient. Please verify and resubmit.
922	Duplicate component billed on same compound claim.
935	Invalid billing of procedure code.
957	Other coverage indicator is missing or invalid. Please correct and resubmit.

EOB message code	EOB message description
976	Resubmit on paper for special handling.
979	Pharmaceutical Care code must be billed with a payable drug detail.
994	Compound drugs require a minimum of two components with at least one payable Medicaid covered drug.
996	Denied, limitation exceeded.